Exhibit Q

PAN AMERICAN LIFE

August 25, 2006

Donna Mathews
REDACTED
Calistoga, CA 94515

Dear Ms. Mathews,

The purpose of this letter is to acknowledge the receipt of your fax dated August 23, 2006 and to address the issues you have raised.

First, the letters dated May 17, 2006 address the overdrafts that occurred on your accounts. Policy #1285-764 was drafted for $652.71 and policy #1257-758 was drafted for $499.20. Both of these amounts are the yearly premium amounts for the respective policies. As was explained to you directly in phone conversations, there was no indication in our system that an amount of $1189.61 was drafted. A total of $1151.91 was identified as being over drafted. It was requested that you forward a bank statement illustrating the amount in question. This information was never received.

The reimbursed amounts of $406.80 and $534.57 accurately reflect the amount that should have been refunded at the time. Your attending physician Dr. Alexander provided a written statement indicating that you were cleared to return to work on March 15, 2006. Your premiums were waived from 12/14/06 through 03/15/06 in the amount of $88.40 for 1285-764 and $114.14 for policy # 1257-758. These amounts were refunded to you in checks dated March 10, 2006 (please see attachment 1). As you were cleared to return to work your policy was placed back into premium paying status.

Premium amounts for April and May for both policies were retained in order to keep your policy in force as was indicated in the refund letter dated May 17, 2006 (please see attachment 2). The letters state: "The policy is now paid until June 6, 2006." As your policies were in premium paying status as of March 15, 2006, premiums needed to be applied for April and May in order to keep your policy active. Pan American Life did not receive any indication that you wanted to terminate your policies so the premiums for April and May were applied in sums of $88.40 for policy #1285-764 and $114.14 for policy #1257-758.

On April 3, 2006 we received a new correspondence from a new attending physician Dr. Brown stating that you were disabled with no estimated return to work date. Pan American Life requested medical records from this physician as is our policy when evaluating disability claims. While these records were being requested your policy remained in premium paying status as we had already received information from your initial physician which indicated that you were recovered and able to return to work.

Please find enclosed premium refund checks (attachment 3) for April and May 2006 in the amounts of $88.40 for policy #1285-764 and $114.14 for policy #1257-758. Your policies entitle a waiver of premiums while on disability. Currently all premiums have been waived or refund beginning in 12/14/05.

Secondly, you state that your understanding of your policies is that: "it guaranteed the protection of my income between $3,000 to $4,000 per month." Your policies are as follows: Policy 1257-758 is an Income Protector policy with a 60 day elimination period. The policy will pay a base benefit of $500 a month up to a five (5) year period. There are no attached riders. Policy #1257-758 is also an Income Protector policy with a 60 day elimination period. The policy will pay a base benefit of $1,300.00 for up to a five (5) year period. The

REDACTED

policy has a social insurance rider and an additional monthly benefit rider. Each of these riders will pay $400.00 when activated.

Your policies currently pay a total of $2200.00, $500.00 (base benefit) for policy 1257-785 and $1300.00 (base benefit) plus $400.00 from your additional monthly benefit for 1285-764. These are the benefits you selected on your applications (policy # 1285-764 signed on March 27, 1991 pg. 3 and policy # 1257-758 acknowledged on September 2, 2005. Please see attachment 4)

Thirdly, all the payments you have been issued clearly state on both the check and the explanation of benefits letter the time period the benefits are covering (Please see attached copies of both your benefit checks and the accompanying explanation letters in attachment 5). You will note that the date range is of the benefits are indicated in the fields marked "monthly benefit from" on the explanation letter and on the third line of print starting from the top of the check header "monthly benefits from." These fields have been highlighted for easier identification.

To date you have received the following benefits:

Policy 1257-758	Policy 1285-764
12/14/05 to 02/14/05 Elimination Period	12/14/05 to 02/14/05 Elimination Period
02/14/06 to 03/14/06 $500.00 check #063032874	02/14/06 to 03/14/06 $1,700 check #063032875
03/14/06 to 04/14/06 $1300.00 check #063037872	03/14/06 to 04/14/06 $1,700 check #063037871
04/14/06 to 05/14/06 -$500.00 Explanation of Benefits	04/14/06 to 05/14/06 $1,700 check #063038875

Please note that as of the time of this writing Pan American Life has paid a total of $6,900.00 dollars. A total of $1800.00 (currently overpaid by $300.00) for 3 months of benefits on policy #1257-758 which pays $500.00 a month and $5,100.00 for 3 months of benefits on policy #1285-764. The policy pays $1,700.00 a month in benefits. In summary for three months of benefits you are entitled to $6,600 dollars of benefits. You have been paid $6,900.00.

Your letter states: "My disability began December 14, 2005, so including the sixty day waiting period I was entitled to full benefit compensation beginning February 14, 2006. This has not happened." Please review the accompanying copies of both your benefit checks (attachment 5) including the check header with dates and your itemized explanation of benefits. Both of these fields clearly indicate the benefit periods for which you have been paid.

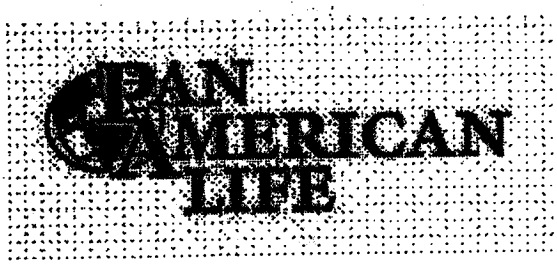
As for your rehabilitation plan Pan American Life will not be extending benefits.

Thank you for allowing Pan American Life to serve your needs.

Sincerely,

Michael Jones
Senior Claim Examiner
Pan American Life
P.O. Box 60219
New Orleans, LA 70160-0219

Attachment 1



Donna Dupell-Mathews
REDACTED
Calistoga, CA 94515

March 13, 2006

RE: Policy # 1285-764

Dear Mrs. Dupell-Mathews:

We have evaluated the claim papers submitted and have approved the application for waiver of premium disability benefits effective December 14, 2005.

We are enclosing our check representing refund of premiums for a total of $114.14.

Future premiums will be waived as long as you continue to be disabled within the meaning of the disability agreement and the Company reserves the right to require evidence of your continued disability in accordance with the previsions thereof. You will be advised when such evidence is desired.

We certainly hope your health will improve soon.

Sincerely

Michael Jones
Senior Claims Examiner

Pan American Life
Policy Benefits
P.O. Box 60219
New Orleans, LA 70160-0219

REDACTED

000059 ENDORSEMENT OF THIS CHECK MUST BE WRITING OF PAYEE OR PAYEES EXACTLY IN CONFORMIT THE NAME OR NAMES AS WRITTEN 300OT 12

84-13
654

NO. 062034850

PAN AMERICAN LIFE

0012857640

AMOUNT
$********114.14**

PAY TO THE ORDER OF:

DONNA R DUPELL-MATHEWS
REDACTED
CALISTOGA CA 94515

MAR 13 2006

$114.14
DOLLAR ONE ONE FOUR PEN ONE FOUR

DATE
MAR 10,2006

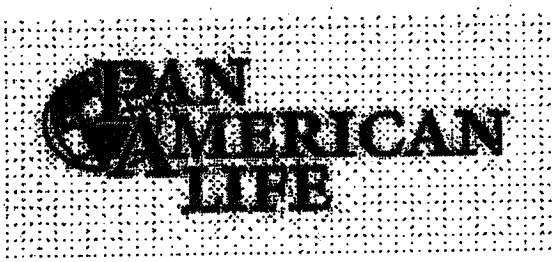
NOT VALID AFTER
90 DAYS OF ISSUE

BANK ONE
NEW ORLEANS, LA.

NON NEGOTIABLE

⑈062034850⑈ ⑆065400137⑆ 01100295 18⑈

REDACTED



Donna Dupell-Mathews

REDACTED
Calistoga, CA 94515

March 13, 2006

RE: Policy # 1257-7580

Dear Mrs. Dupell-Mathews:

We have evaluated the claim papers submitted and have approved the application for waiver of premium disability benefits effective December 14, 2005.

We are enclosing our check representing refund of premiums for a total of $88.40.

Future premiums will be waived as long as you continue to be disabled within the meaning of the disability agreement and the Company reserves the right to require evidence of your continued disability in accordance with the previsions thereof. You will be advised when such evidence is desired.

We certainly hope your health will improve soon.

Sincerely

Michael Jones
Senior Claims Examiner

Pan American Life
Policy Benefits
P.O. Box 60219
New Orleans, LA 70160-0219

REDACTED

ENDORSEMENT OF THIS CHECK MUST BE ... IDWRITING OF PAYEE OR PAYEES EXACTLY IN CONFORMITY ... THE NAME OR NAMES AS WRITTEN 3000T 12

84-13 / 654

NO. 062034849

PAN AMERICAN LIFE

0012577580

AMOUNT
$*********88.40**

PAY TO THE ORDER OF:

DONNA R DUPELL-MATHEWS
REDACTED
CALISTOGA CA 94515

DATE
MAR 10,2006

NOT VALID AFTER 90 DAYS OF ISSUE

MAR 13 2006

$88.40

BANK ONE
NEW ORLEANS, LA.

NON NEGOTIABLE

⑈062034849⑈ ⑆065400137⑆ 011002951 8⑈

REDACTED

Attachment 2

PAN AMERICAN LIFE

May 17, 2006

Donna Mathews
REDACTED
Calistoga CA 94515

Re: Policy # 1257-758 & # 1285-764
Claim # 06-1007 & # 06-1005

Dear Ms. Mathews:

Please find enclosed refunds for premium withdrawals taken on April 12, 2006 for policies # 1257-758 and # 1285-764. These withdrawals were made at the annual billing rate for your policies instead of the monthly billing rate.

An amount of $499.20 was deducted to pay policy # 1257-758. The refund amount will be $406.80. The policy is now paid to June 6, 2006. Your monthly premium rate is $46.20.

An amount of $652.71 was deducted to pay policy # 1285-764. The refund amount will be $534.57. The policy is now paid to June 6, 2006. Your monthly premium rate is $59.07.

Sincerely,

Michael Jones
Senior Claim Examiner
Pan American Life
P.O. Box 60219
New Orleans, LA 70160-0219

REDACTED

000061 ENDORSEMENT OF THIS CHECK MUST BE WRITING OF PAYEE OR PAYEES EXACTLY IN CONFORMITY THE NAME OR NAMES AS WRITTEN 300OT 12

84-13
654

No.062040332

PAN AMERICAN LIFE

0012577580

AMOUNT
$********406.80**

PAY TO THE ORDER OF:

DONNA R DUPELL-MATHEWS

REDACTED

CALISTOGA CA 94515

JC

MAY 17 2006

$406.80

DATE
MAY 16,2006

NOT VALID AFTER
90 DAYS OF ISSUE

BANK ONE
NEW ORLEANS, LA.

NON NEGOTIABLE

⑈062040332⑈ ⑆065400137⑆ 01100295 18⑈

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PAN AMERICAN LIFE

May 17, 2006

Donna Mathews
REDACTED
Calistoga CA 94515

Re: Policy # 1257-758 & # 1285-764
Claim # 06-1007 & # 06-1005

Dear Ms. Mathews:

Please find enclosed refunds for premium withdrawals taken on April 12, 2006 for policies # 1257-758 and # 1285-764. These withdrawals were made at the annual billing rate for your policies instead of the monthly billing rate.

An amount of $499.20 was deducted to pay policy # 1257-758. The refund amount will be $406.80. The policy is now paid to June 6, 2006. Your monthly premium rate is $46.20.

An amount of $652.71 was deducted to pay policy # 1285-764. The refund amount will be $534.57. The policy is now paid to June 6, 2006. Your monthly premium rate is $59.07.

Sincerely,

Michael Jones
Senior Claim Examiner
Pan American Life
P.O. Box 60219
New Orleans, LA 70160-0219

REDACTED

00006 ENDORSEMENT OF THIS CHECK MUST BE WRITING OF PAYEE OR PAYEES EXACTLY IN CONFORMITY THE NAME OR NAMES AS WRITTEN 300OT 12

84-13
654

No. 062040333

PAN AMERICAN LIFE

0012857640

AMOUNT
$********534.57**

PAY TO THE ORDER OF:
DONNA R DUPELL-MATHEWS
REDACTED
CALISTOGA CA 94515

JC

$534.57
DOLLAR FIVE THREE FOUR PER FIVE SEVEN

DATE
MAY 16,2006

NOT VALID AFTER
90 DAYS OF ISSUE

MAY 17 2006

BANK ONE
NEW ORLEANS, LA.

NON NEGOTIABLE

⑈062040333⑈ ⑆065400137⑆ 01100295 18⑈

REDACTED

REDACTED

Attachment 3

THIS MULTI-TONE AREA OF THE DOCUMENT CHANGES COLOR GRADUALLY AND EVENLY FROM DARK TO LIGHT WITH DARKER AREAS BOTH TOP AND BOTTOM

ENDORSEMENT OF THIS CHECK MUST BE IN ... OF PAYEE OR PAYEES EXACTLY IN CONFORMITY WITH THE NAME OR NAMES AS WRITTEN

No 062047309

PAN AMERICAN LIFE

0012577580

AMOUNT

$*********88.40**

PAY TO THE ORDER OF:

DONNA R DUPELL-MATHEWS

REDACTED

CALISTOGA CA 94515

DATE

AUG 25,2006

$88.40

NOT VALID AFTER 90 DAYS OF ISSUE

BANK ONE
NEW ORLEANS, LA.

Denyse Haar Schomaker

Lory Anne Dupuy

⑈062047309⑈ ⑆065400137⑆ 0110029518⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

THIS MULTI-TONE AREA OF THE DOCUMENT CHANGES COLOR GRADUALLY AND EVENLY FROM DARK TO LIGHT WITH DARKER AREAS BOTH TOP AND BOTTOM

No 062047310

PAN AMERICAN LIFE

0012857650

AMOUNT

$********114.14**

PAY TO THE ORDER OF:

DONNA R DUPELL-MATHEWS

REDACTED

CALISTOGA CA 94515

DATE

AUG 25,2006

$114.14

NOT VALID AFTER 90 DAYS OF ISSUE

BANK ONE
NEW ORLEANS, LA.

Denyse Haar Schomaker

Lory Anne Dupuy

⑈062047310⑈ ⑆065400137⑆ 0110029518⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

REDACTED

Attachment 4

AMENDMENT OF APPLICATION

TO: Pan-American Life Insurance Company
New Orleans, Louisiana, USA

Date Prepared: 7-25-05
Policy Number: 0012577580

I, **Donna Dupell-Mathews**, hereby desire to amend my application for: life insurance; or accident and sickness insurance; or both made to you on the 1st day of **May 2005** as follows:

- Insured's age 52 nearest birthday
- Premiums payable on a Monthly Bank Draft basis
- Issue with Policy Date of July 6, 2005
- Issue with Occupational Class 2A
- Issue with Monthly Benefit of $500.00
- Issue with Benefit Period-5 years
- Issue with Elimination Period-60 days

The above amendment and declaration are to be taken and considered as part of the said application, and subject to the agreements and representations therein contained, and with the said application to be taken as a whole, and considered as the basis of the contract for insurance. This Company is authorized to modify said application to conform hereto.

Witness	Insured: Donna Dupell-Mathews	Date: 9-2-05
Witness: N/A	Owner (if other than Insured): N/A	Date

Form A-1704

21,134

PAN-AMERICAN LIFE INSURANCE COMPANY
PAN-AMERICAN ASSURANCE COMPANY
P.O. BOX 60219, NEW ORLEANS, LOUISIANA 70160

PART I OF APPLICATION
PLEASE PRINT

If more space is needed, see Special Instructions on page 6	DOB Mo./Day/Yr.	Age Nearest Birthday	Sex M/F	Rate Class SM/NS/Pref.	Social Security Or Tax Number	Birth State
1. Proposed Insured (Print full name, last, first, middle) MATHEWS, DONNA	REDACTED 53	37	F	WS/Pref	REDACTED	CA

2. If Proposed Insured is under age 15, what is the Total Amount of Life Insurance on Parent or Guardian?
Total Amount $ N/A

3.(a) Proposed Insured's Residence Address: REDACTED No. and Street CALISTOGA City CA State 94515 Zip Code (b) Home Phone REDACTED

4(a) Name of Employer SELF (b) Nature of Employer's Business DENTAL HYGENIEST

5.(a) Business Address AS ABOVE No. and Street City State Zip Code (b) Business Phone (707) 942-4760

6. (a) Describe Exact Daily Duties of Proposed Insured's Occupation: DENTAL HYGENIEST % Traveling 0

(b) How long in present occupation: 15 YRS. Is Proposed Insured presently working? ☒ Yes ☐ No

(c) Other Employment last 3 years N/A

(d) Does Proposed Insured have any other Part-Time or Full-Time job? ☐ Yes ☒ No

(If yes, give full details)

7. (a) Owner if other than Proposed Insured	(b) Relationship	(c) Social Security/Tax #	(d) Sex M/F
N/A			
(e) Contingent Owner			

(f) Address of Owner Contingent Owner No. and Street City State Zip Code (g) If Corp., where incorporated

8. Beneficiary (State full name and relationship. If more than one, then equally to the survivors unless Primary and Contingent are specified)
ARTHUR JOSEPH MATHEWS, HUSBAND

Reserve right to change? ☒ Yes ☐ No (Select "No" for irrevocable Beneficiary)

9. Send Notices to ☒ Residence ☐ Business ☐ Owner ☐ Other (Specify) 10. Specific Policy Date Requested, if any

11. Premiums payable: ☐ Single ☐ A ☐ S ☐ Q ☒ PAC ☐ M (PALIC products only)
Total Cash collected with this application $ 55.07 (Questions 13, 17 and 28)
PAC Draw Day 15th Combine with policy # N/A
☐ Salary Savings Payroll No. ☐ Gov't Allot. Branch of Service Pay Grade

FORM A-2900 (CA) Page 1

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21,134

PRODUCT DETAIL

Adjustable Life Insurance (Universal)

12. (a) Plan: N/A	(b) Specified Amount $	(c) Death Benefit Options ☐ Option 1 (Level) ☐ Option 2 (Increasing)
(d) Planned Payments $ ~~5~~ Per	(e) Additional Lump Sum Payment $	13. Cash With App. $ (Not allowed if Specified Amount + Riders exceeds $500,000)

14. ADDITIONAL BENEFITS AND RIDERS:
☐ Waiver of Monthly Deductions Rider ☐ Guaranteed Insurability Rider _____ units
☐ Acc. Death Benefit Rider Amt. $_____ ☐ Nursing Care Rider
☐ Dis. Benefit Payment Rider Amt. $_____ ☐ Other Rider _____

Whole Life/Term Insurance

15. Plan: N/A	16. (a) ☐ Basic Amt. $ _____ or ☐ Amt. purchased by premium of $ _____	(b) Total Amt. (Basic + Rider) $ _____

17. Cash With App. $_____ (Not allowed if Total Amount exceeds $500,000)

18. ADDITIONAL BENEFITS AND RIDERS :
☐ Waiver of Prem. ☐ Acc. Death $ _____ ☐ Guar. Insurability_____ units
☐ Paid-Up Ins: No. Yrs. ___ ☐ Single Prem. Paid-Up Ins. ☐ R & C Term _____ yr. _____ units
☐ Amt. purchased by premium of $_____ ☐ Decr. Term _____ yr. _____ units
or ☐ Rider Amount of Insurance $_____ ☐ Other Rider _____

19. ☐ Automatic Premium Loan (if available) 20. ☐ Annuity Purchase Prov. (N/A with Term Plans)

21. Dividends: Indicate primary option desired ☐ 1 Yr. Term (Secondary Option:
☐ Pay In Cash ☐ Reduce Premiums* ☐ Paid-Up Additions
☐ Paid-Up Additions ☐ Leave on Deposit (W-9 Required) ☐ Leave on Deposit (W-9 Required)
☐ Flexible Coverage (Percentage _____) ☐ Reduce Premiums*)
*(Reduce Prems. options cannot be elected with Monthly modes)

Questions 22 thru 26 apply to riders proposed for insurance. If more space needed, see Special Instructions, Page 6A.

22. Other Riders (Print full name, last, first, middle) N/A	Amount	DOB Mo./Day/Yr.	Age Nearest Birthday	Sex M/F	Rate Class SM/NS/Pref.	Social Security Or Tax Number	Birth State
Spouse Rider - With ☐ Adj. Life ☐ WL							
Dependent Children Rider - With ☐ Adj. Life ☐ WL							
Add'l Ins. Rider (Proposed Insured)							
Add'l Ins. Rider (Other)							
Beneficiary Ins. Purch. Rider (Designated Life) With ☐ Adj. Life ☐ WL							
Nominator Rider ☐ Death ☐ Death or Dis.							

Page 2

21,134

23. Show any beneficiaries for Additional Insured Rider:

Additional Insured	Beneficiary	Relationship

24. Other Proposed Insureds — Residence Address (If Different From Basic Insured) — No. and Street — City — State — Zip Code

25. Relationship to Insured

26. (a) Name of Employer

(b) Occupation/Duties

(c) Business Address — No. & Street — City — State — Zip Code

Disability Income Insurance

27. Plan	Rate Class SM/NS/Pref.	Occupational Class	Elimination Period	Benefit Period	Monthly Benefit
(a) ☒ Income Protection	PREF	2A+	90 days	5 YEARS	$ 1800
(b) ☐ Overhead Expense			days		$

28. Cash With App. $ 55.07 (Not allowed if total Monthly Benefit including Riders exceeds $3,000.

29. ☐ Employer Pays Premiums (Benefits taxable to Employee) ☒ Employee Pays Premiums (Benefits not taxable)

30. ADDITIONAL BENEFITS AND RIDERS:

IP / O / H / L / T

- ☐ Regular Occupation Rider
- ☐ Lifetime Extended Benefit ☐ Hospital Benefit
- ☐ Cost of Living Rider ☐ 5% ☐ 7%
- ☒ Add'l Mo. Benefit Elim. Pd. 90 Days Amt. $ 900
- ☒ Soc. Ins. Rider ☒ 5 yr. ☐ To Age 65 Amt. $ 900
- ☒ Future Purchase Option: Amt. $ 1000 (IP) - Amt. $ _____ (OE)
- ☐ Cash Value Rider - ☐ IP ☐ OE
- ☐ Capital Accumulator Rider - ☐ IP ☐ OE
- ☐ Retroactive Coverage (OE)
- ☐ Other Rider

31. If applying for Disability Income Insurance is Proposed Insured eligible for:

Group-Disability Insurance Benefits	Salary Continuation From Employer	State Cash Sickness	Worker's Compensation	Union or Other Disability Benefits
☐ Yes ☒ No ☐ Not Covered $ Per Mo. for Mos.	☐ Yes ☒ No $ Per Mo. for Mos.	☒ Yes ☐ No $100 Per Mo.	☐ Yes ☒ No $ Per Mo.	☐ Yes ☒ No $ Per Mo.

32. (a) Proposed Insured's earned income less deductible expenses:
At current annual rate $ 28-32K Prior calendar year $ 27,200

(b) Does unearned income exceed $10,000 per year? ☐ Yes ☒ No (If "Yes" complete Financial Questionnaire attached.)

(c) Does net worth exceed $1,000,000? ☐ Yes ☒ No (If "Yes", complete Financial Questionnaire attached.)

If applying for Overhead Expense Insurance, complete questions 33 and 34.

33. Are Proposed Insured's office expenses shared with anyone else? ☐ Yes ☐ No If "Yes", Proposed Insured's % ____

34. Complete the following. Use Proposed Insured's actual current average monthly expenses. If expenses are shared, include only Proposed Insured's portion. Exclude any payments to Proposed Insured, to any other member of Proposed Insured's profession, or family members.

Rent	$ N/A	Depreciation	$	Liability Insurance	$
Electricity	$	Salaries	$	Property Taxes	$
Heat & Water	$	Telephone	$	Mortgage Interest	$
Other normal and customary fixed office expenses (Give full details if over 10% of total)	$			Total	$

Page 3

21,134

EVIDENCE OF INSURABILITY

Questions 35-37 must always be completed. Questions 38-40 must be completed for all non-medical insurance and are helpful in other cases. Questions must be completed for every person proposed for insurance. (If more space is needed, use "Details" section)

	Yes	No	Details of "Yes" Answers (Identify question number and person(s) proposed for insurance; circle applicable items.)
35. Has anyone proposed for insurance: (a) Ever been declined, postponed, rated or modified for life, health, or disability insurance?	☐	☒	
(b) Submitted any application for life, health, or disability insurance or reinstatement of same which is now pending in any company?	☐	☒	
(c) Ever engaged in any type of flying as pilot, student pilot, or crew member of any aircraft including ultralight planes, or expect to in the future? (If "Yes", complete Aviation/Avocation Questionnaire)	☐	☒	
(d) Participated in any auto or motorcycle racing, skin or scuba diving, parachuting, hang gliding, ballooning or expect to in the future? (If "Yes", complete Aviation/Avocation questionnaire)	☐	☒	
(e) Within the past five years been convicted of or pleaded guilty to: (1) Two or more moving violations and/or accidents? (If "Yes," include Driver's License No. ______)	☐	☒	
(2) Driving under the influence of alcohol and/or drugs?	☐	☒	
(f) Ever been arrested other than for moving violations?	☐	☒	
(g) Any intention of traveling or living outside the U.S.A. in the next two years?	☐	☒	

36. Insurance currently in force on each person proposed for insurance (Life, Health, Disability, Long Term Care policies or riders to other policies)

Name	Company	Policy Number	Year of Issue	Amount	Benefit Period	Accid. Death Amount	Prem. Waiver Yes/No	To Be Replaced Yes/No
DONNA	PENN MUTUAL	" CHILDHOOD		1,000	(LIFE)			

37. Do you intend the replacement or change of any existing Life, D.I., Health, or Annuity contracts in connection with this application for new insurance? ☐ Yes ☐ No (If "Yes", forward any required replacement forms, or sales proposals)

38. Height and Weight information on person(s) proposed for insurance.

Name	Height (ft. ins.)	Weight (lbs.)	Weight gained in past year	Weight lost in past year
DONNA	5' 7"	135	—	—

39. (a) Name, address and telephone number of personal physician for each person(s) proposed for insurance (if none, so state). DR. STILES DEER PARK, CA

(b) Date and reason last consulted. PHYSICAL (ANNUAL)

(c) What treatment was given or medication prescribed? NONE

(Questions Continued on Next page.

21,134

	Yes	No
40. To the best of your knowledge and belief, within the last 10 years, has anyone proposed for insurance ever been medically diagnosed with or treated for:		
(a) Disorder of eyes, ears, nose or throat?		☒
(b) Dizziness, fainting, convulsions, headache, paralysis, stroke, mental or nervous disorder?		☒
(c) Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?		☒
(d) Intestinal bleeding, ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?		☒
(e) Sugar, albumin, blood or pus in urine, menstrual disorder, venereal disease or other disorder of kidney, bladder, breasts, prostate or reproductive organs?	☒	
(f) Diabetes, thyroid or other endocrine disorders?		☒
(g) Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles, bones, spine, back or joints?		☒
(h) Deformity, lameness or amputation?		☒
(i) Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart, or blood vessels?		☒
(j) Allergies, anemia or other disorder of the blood?		☒
(k) Disorder of skin, lymph gland, cyst, tumor, or cancer?		☒
(l) Acquired Immune Deficiency Syndrome (AIDS), or the AIDS related complex (ARC), or tested positive for antibodies to the "AIDS" virus in connection with a prior application for insurance?		☒
(m) Alcoholism?		☒
(n) Use of, except as prescribed by a physician, narcotics, barbiturates, hallucinogens, tranquilizers?		☒
41. Is anyone proposed for insurance currently under observation or treatment by a physician or a medical facility?		☒
42. Other than above (40a through 40n) has anyone proposed for insurance within the past five years: (a) Had a check-up, illness, injury, surgery?	☒	
(b) Been a patient in a hospital, clinic, sanatorium?	☒	
(c) Had EKG, X-Ray, other diagnostic test?		☒
(d) Been advised to have any diagnostic test or surgery, which was not completed?		☒
43. Has anyone proposed for insurance ever had military service deferment, rejection or discharge because of a physical or mental condition?		☒
44. Has anyone proposed for insurance ever requested or received a pension, benefits, or payment because of an injury, sickness, or disability?		☒
45. Is anyone proposed for insurance now pregnant?		☒

Details of "Yes" answers (Identify question number and person(s) proposed for insurance; circle applicable items. Include diagnosis, dates, durations, treatment and names and address of all attending physicians and medical facilities.)

40 e) ENDOMETRIOSIS — DIAGNOSED 1991
MINIMAL — NO MEDICATION

42 A) ANNUAL PHYSICAL/GYN
1191 PERFECT HEALTH

42 B) CHILDBIRTH
7/20/88
SANTA ROSA COMMUNITY HOSP.
DR. BOB FIELDS
NORMAL DELIVERY

(Details continued on next page)

(Questions Continued on Next page)

Page 5

PAL 0843

21,134

	Yes	No	Details (continued)
46. (a) Is anyone propose[illegible] [illegible] insurance now a cigarette smoker?	☐	☒	
(b) Is anyone currently using tobacco in any form?	☐	☒	
(c) Is anyone a previous tobacco user in any form? What was used? CIGARETTES How much per day? 2 PACKS WEEKLY	☒	☐	47) MOTHER
(d) Has anyone quit during the past 12 months?	☐	☐	
1 Year to 5 years ago?	☐	☐	
or more than 5 years ago?	☒	☐	
(e) Did or does anyone smoke more than one pack daily?	☐	☒	
47. Has any immediate family member ever been medically diagnosed or treated for diabetes, cancer, heart disease,	☒	☐	

48. [illegible]	Age if Living	Age At Death	Cause of Death
Father	72		
Mother		61	LYMPHOMA
Brothers (1) & Sisters (2)	46 / 44 / 39		

Answer question 49 if cash intended to be paid with this application. If yes to either (a) or (b), cash cannot be accepted and conditional receipt must not be given.

49. Within the past 12 months has anyone proposed for insurance:

(a) Been medically diagnosed or treated for heart trouble, stroke, or cancer, consulted a physician for blood pressure requiring medication, or had an electrocardiogram made for any reason other than a routine physical examination? ☐ Yes ☒ No

(b) Is anyone contemplating hospitalization, surgery or of [illegible] next 12 months? ☐ Yes ☒ No

50. Special Instructions (Indicate Life or Disability)

[illegible] ce Endorsement (Not to be used to change plan of insurance, amount, age at issue, classification of risk or benefits. Not to be used for Disability.)

DECLARATION, AUTHORIZATION AND SIGNATURES

The Proposed Insured, (Parent or Guardian if Proposed Insured is under age 15) and Owner, if other than Proposed Insured, Parent or Guardian represent to the best of his or her knowledge, information and belief that the answers and statements made in Parts I and II (if Part II required by the Company) of this application are complete and true. The undersigned agrees that: (1) No waiver or modification of a contract provision or of any of the Company's rights or requirements shall be binding upon the Company unless made in writing and approved by the Company; (2) The acceptance of any issued contract will ratify any change made by the Company in the space "For Home Office Endorsement." However, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the owner's written consent. (3) If, within 60 days from the date of application, no policy is received or I am not notified of approval or rejection, this application shall be deemed declined; (4) $ —0— for life insurances, and $ 55.07 for disability insurances has been paid in cash and the Company's liability will be as stated in the Conditional Receipt. (No other receipt will be valid); (5) If no payment is made with this application, there will be no life insurance, disability insurance or liability until (a) a policy is delivered; (b) the first full premium is paid during the Insured's lifetime, and (c) no change has occured in the health of any person proposed for insurance that would place that person in a higher risk class than at the time of application for this policy. (6) Any contract resulting from this application shall be construed in accordance with the laws of the state named below where this application is signed.

21,134

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or consumer reporting agency that has any records or knowledge of me or my minor child or me or my minor child's health to give to the Pan-American Life Insurance Company, Pan-American Assurance Company, or to its reinsurers any such information in order to evaluate my application for life or disability insurance.

I agree this authorization shall be valid for two and one-half years from the date signed.

I know that I may request a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

The Undersigned acknowledges receipt of the Notice Concerning the Medical Information Bureau, the Fair Credit Reporting Act Disclosure, and the Notice of Insurance Information Practices.

I understand that I may be interviewed if an investigative consumer report is prepared in connection with this application.

Signed at SANTA ROSA, CA (City, State) on this 27th day of MARCH 1991

Signature of Proposed Insured (Parent or Guardian, if Proposed Insured is under age 15)

Application Number
B 02113

N/A
Signature of Owner (if other than Proposed Insured) (if Corporation or Partnership, Officer or Partner other than Proposed Insured must sign.)

N/A
Signature of Spouse if proposed for insurance

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant and that I have personally seen every person proposed for insurance under this application. To the best of my knowledge, replacement of insurance ☐ is ☒ is not involved in this transaction.

N/A
Signature of Add'l Ins. if proposed for insurance

50 %
Signature of Soliciting Agent—Personal Code—Participating %

(Resident Agent)

8540-8540 50%
Signature of Soliciting Agent—Personal Code—Participating %

SCOTT KLOHE 2109-02409 3
Soliciting Agent's Printed Name — Underwriting Team No. (If Known)

MICHAEL P. MCDONALD
Soliciting Agent's Printed Name

21,134

TO: ☐ Pan-American Life Insurance Company ☐ Pan-American Assurance Company

New Orleans, Louisiana 70130

PART II OF APPLICATION

Statements Made by Proposed Insured to Examiner — Do Not Use Typewriter Is Applied

Proposed Insured: Donna K. Mathews — Birth Date REDACTED 53

Last Name | Middle Initial | First Name | Month | Day | Year

1. a. Name and address of your personal physician? (If consulted in the last 10 years. If none, so state) Dr. [illegible] [illegible] Ca.
b. Date and reason last consulted? [illegible] 4/5/91
c. What treatment was given or medication prescribed?

2. To the best of your knowledge and belief, within the last 10 years, have you ever been treated for:	YES	NO
(a) Disorder of eyes, ears, nose or throat?	☐	☑
(b) Dizziness, fainting, convulsions, headache, paralysis, stroke, mental or nervous disorder?	☐	☑
(c) Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☑
(d) Intestinal bleeding, ulcer, hernia, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver gallbladder?	☐	☑
(e) Sugar, albumin, blood or pus in urine, menstrual disorder, venereal disease or other disorder of kidney, bladder, breasts; prostate or reproductive organs?	☑	☐
(f) Diabetes, thyroid or other endocrine disorders?	☐	☑
(g) Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles, bones, spine, back or joints?	☐	☑
(h) Deformity, lameness or amputation?	☐	☑
(i) Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart, or blood vessels?	☐	☑
(j) Allergies, anemia or other disorder of the blood?	☐	☑
(k) Disorder of skin, lymph gland, cyst, tumor or cancer?	☐	☑
(l) An immune deficiency disorder, AIDS or the AIDS related complex (ARC)?	☐	☑
(m)	☐	☑
(n) Use of, except as prescribed by a physician, narcotics, barbiturates, hallucinogens, tranquilizers?	☐	☑
3. Now under observation or taking	☐	☑
4. Other than the above (2a through 2n) have you within the past five years:		
(a) Had a check-up, illness, injury, surgery?	☑	☐
(b) Been a patient in a hospital, clinic, sanatorium?	☐	☑
(c) Had EKG, X-Ray, other diagnostic test?	☐	☑
(d) Been advised to have any diagnostic test, surgery, which was not completed?	☐	☑

	YES	NO
(e) Have you ever requested or received a pension, benefits, or payment because of an injury, sickness, or disability?	☐	☑
5. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☑
6. Family History: Diabetes, cancer, heart disease, mental illness?	☑	☐
7. Are you now pregnant?	☐	☑
8. (a) Are you now a cigarette smoker?	☐	☑
(b) Have you been a smoker and quit?	☑	☐
(c) Did you quit during the past 12 months?	☐	☑
(d) or more than 1 year ago?	☑	☐
(e) Did or do you smoke more than one pack daily?	☐	☑

DETAILS OF "Yes" ANSWERS (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS) Include diagnosis, dates, durations, treatment and names and addresses of ALL attending physicians and medical facilities.)

(2e) diag c Endometriosis 1978 — [illegible] Annual paps with Dr. R. Fields 3315 Chanate Rd Santa Rosa Ca [illegible] mammogram [illegible]
(4a) [illegible] post partum care normal delivery 7-6-88 Dr. Fields
(6) Mother died lymphoma [illegible]

9. Family Record	Age if Living	Cause of Death	Age at Death
Father			
Mother		[illegible]	[illegible]
Brothers & Sisters	46 44 48 38		

I agree that the foregoing answers are complete and true to the best of my knowledge, information and belief and shall be part of my application which shall consist of Parts I and II taken together.

Signed at [illegible] on the [illegible] day of April, 1991

Witnessed by [illegible] — [illegible] Signature of Proposed Insured

REDACTED

Attachment 5

STATEMENT

DESCRIPTION OF BENEFITS		AMOUNT
POLICY NO. 1257758 CLAIM NO. 061005 MONTHLY BENEFITS FROM 031406 TO 041406 INSURED: DONNA MATHEWS	DAYS	1,300.00

JUL 14 2006

CHECK NO. 063037872 CHECK AMOUNT $1,300.00

THE ATTACHED CHECK COVERS FULL PAYMENT OF ITEMS SHOWN IN STATEMENT ABOVE. PLEASE DETACH THIS STATEMENT BEFORE PRESENTING CHECK FOR PAYMENT.

PAN-AMERICAN LIFE INSURANCE COMPANY

000012 ENDORSEMENT OF THIS CHECK MUST BE IN HANDWRITING OF PAYEE OR PAYEES EXACTLY IN CONFORMITY WITH THE NAME OR NAMES AS WRITTEN 280AH AH

84-13
654

PAN AMERICAN LIFE

NO. 063037872

AMOUNT
$******1,300.00**

PAY TO THE ORDER OF:

DONNA MATHEWS
REDACTED
CALISTOGA GA 94515

$1,300.00
DOLLAR ONE CON THREE ZERO ZERO PER ZERO ZERO

DATE
JUL 13,2006

NOT VALID AFTER
90 DAYS OF ISSUE

BANK ONE
NEW ORLEANS, LA.

NON NEGOTIABLE

⑈063037872⑈ ⑆065400137⑆ 01100294 37⑈

REDACTED

ACCIDENT AND HEALTH CLAIM CHECK REQUEST/ WORK SHEET

POLICY NUMBER										DATE		
1257-758	CALIFORNI											
FORM NUMBER	BO	ST/CTRY	AGENCY	AGENT	AGENT	CLAIM NUMBER	INS.	AGE	INCURR DATE	REPORT DATE	CAUSE	A/S	COINS
7h01		4				06-1005	1	53	12/14/2006	2/6/2006	419		
CDS CODE	CASH ACCOUNT	CHECK AMOUNT		AUTH		NO.CHK	NO ACCT	CHECK NUMBER	9/1/2004				
A1	51448	$	1,300.00	MRJ1					CRAH	607073			

CDS CODE	ACCOUNT	A & H CD	TOTAL CHARGES	INELEGIBLE	SEE REV	100% BENEFITS	ELEGIBLE CHARGES	BENEFITS AT %
BB	12200	07						
CB	12200	08						
DB	12200	09						
EB	12200	10						
FB	12200	11						
GB	12100	01				1,300.00		
HB								
IB								
JB								
KB								
LB								
MB								
TOTAL			$			$ 1,300.00	$	

CDS CODE	TYPE OF CHARGE			
BS	HOSPITAL ROOM AND BOARD FROM		TO	
	MISC. HOSPITAL CHARGES			
	SURGERY			
	MATERNITY BENEFIT			
	OUT PATIENT BENEFIT-ACCIDENT			
GS	MONTHLY BENEFIT FROM	03/14/06	TO	04/14/06
HS	1 MONTHLY BENEFT			
IS				
JS				
KS				
LS				
MS				

CDS CODE	INSURED	TAX ID
TS	DONNA MATHEWS	

CDS CODE	PAYEE NAME AND ADDRESS
Y1	DONNA MATHEWS
Y2	REDACTED
Z1	CALISTOGA, GA 94515
Z2	
Z3	

PREPARED BY	APPROVAL
ELAINE BOURG	

REDACTED

PAL 0849

STATEMENT

DESCRIPTION OF BENEFITS		AMOUNT
POLICY NO. 1257758 CLAIM NO. 061005 MONTHLY BENEFITS FROM 021406 TO 031406 INSURED: DONNA MATHEWS	DAYS	500.00

CHECK NO. 063032874 CHECK AMOUNT $500.00

THE ATTACHED CHECK COVERS FULL PAYMENT OF ITEMS SHOWN IN STATEMENT ABOVE. PLEASE DETACH THIS STATEMENT BEFORE PRESENTING CHECK FOR PAYMENT.

PAN-AMERICAN LIFE INSURANCE COMPANY

000002 ENDORSEMENT OF THIS CHECK MUST BE IN HANDWRITING OF PAYEE OR PAYEES EXACTLY IN CONFORMITY WITH THE NAME OR NAMES AS WRITTEN 280AH AH

84-13/654 NO. 063032874

PAN AMERICAN LIFE

AMOUNT
$********500.00**

$500.00

DATE
MAR 06,2006

NOT VALID AFTER 90 DAYS OF ISSUE

PAY TO THE ORDER OF:
DONNA MATHEWS
REDACTED
CALISTOGA CA 94515

MAR 07 2006

BANK ONE
NEW ORLEANS, LA.

NON NEGOTIABLE

⑈063032874⑈ ⑆065400137⑆ 011002943 7⑈

REDACTED

PAL 0850

ACCIDENT AND HEALTH CLAIM CHECK REQUEST/ WORK SHEET

POLICY NUMBER										DATE		
1257-758	CALIFORNI									3/6/2006		
FORM NUMBER	BO	ST/CTRY	AGENCY	AGENT	AGENT	CLAIM NUMBER	INS.	AGE	INCURR DATE	REPORT DATE	CAUSE	A/S	COINS
7H01		4				06-1005	1	53	12/14/2005	2/6/2005	419		
CDS CODE	CASH ACCOUNT	CHECK AMOUNT		AUTH		NO.CHK	NO ACCT	CHECK NUMBER	REQUEST NUMBER				
A1	51448	$ 500.00		MRJ1					CRAH 603050				

CDS CODE	ACCOUNT	A & H CD	TOTAL CHARGES	INELEGIBLE	SEE REV	100% BENEFITS	ELEGIBLE CHARGES	BENEFITS AT %
BB	12200	07						
CB	12200	08						-
DB	12200	09						
EB	12200	10						
FB	12200	11						
GB	12100	01				500.00		
HB								
IB								
JB								
KB								
LB								
MB								
TOTAL			$ 0			$ 500.00		

CDS CODE	TYPE OF CHARGE				
BS	HOSPITAL ROOM AND BOARD FROM		TO		
	MISC. HOSPITAL CHARGES				
	SURGERY				
	MATERNITY BENEFIT				
	OUT PATIENT BENEFIT-ACCIDENT				
GS	MONTHLY BENEFIT FROM	02/14/06	TO	03/14/06	
HS	1 Monthly Benefit				
IS					
JS					
KS					
LS					
MS					

CDS CODE	INSURED	TAX ID
TS	Donna Mathews	

FINAL BENEFIT - RETURNED TO WORK

CDS CODE	PAYEE NAME AND ADDRESS
Y1	Donna Mathews
Y2	REDACTED
Z1	CALISTOGA, CA 94515
Z2	
Z3	

PREPARED BY	APPROVAL
ELAINE BOURG	

REDACTED

PAL 0851

STATEMENT

DESCRIPTION OF BENEFITS		AMOUNT
POLICY NO. 1257758 CLAIM NO. 061005		
MONTHLY BENEFITS FROM 041406 TO 051406	DAYS	1,300.00
ABI 041406 051406		400.00
INSURED: DONNA MATHEWS		

CHECK NO. 063038875 CHECK AMOUNT $1,700.00

THE ATTACHED CHECK COVERS FULL PAYMENT OF ITEMS SHOWN IN STATEMENT ABOVE. PLEASE DETACH THIS STATEMENT BEFORE PRESENTING CHECK FOR PAYMENT.

PAN–AMERICAN LIFE INSURANCE COMPANY

000017 ENDORSEMENT OF THIS CHECK MUST BE IN HANDWRITING OF PAYEE OR PAYEES EXACTLY IN CONFORMITY WITH THE NAME OR NAMES AS WRITTEN 280AH AH

84–13 / 654 NO. 063038875

PAN AMERICAN LIFE

AMOUNT
$******1,700.00**

PAY TO THE ORDER OF:

DONNA MATHEWS
REDACTED
CALISTOGA GA 94515

$1,700.00

DATE
AUG 12, 2006

AUG 14 2006

NOT VALID AFTER 90 DAYS OF ISSUE

BANK ONE
NEW ORLEANS, LA.

NON NEGOTIABLE

⑈063038875⑈ ⑆065400137⑆ 0110029437⑈

REDACTED

ACCIDENT AND HEALTH CLAIM CHECK REQUEST/ WORK SHEET

POLICY NUMBER										DATE				
~~4257-758~~ 1286764		CALIFORNI												
FORM NUMBER	BO	ST/CTRY	AGENCY	AGENT	AGENT	CLAIM NUMBER	INS.	AGE	INCURR DATE	REPORT DATE	CAUSE	A/S	COINS	
7h01		4				06-1005	1	53	12/14/2006	2/6/2006	419			
CDS CODE	CASH ACCOUNT	CHECK AMOUNT		AUTH		NO.CHK	NO ACCT	CHECK NUMBER	9/1/2004					
A1	51448	$ 1,700.00		MRJ1					CRAH	608066				

CDS CODE	ACCOUNT	A & H CD	TOTAL CHARGES	INELEGIBLE	SEE REV	100% BENEFITS	ELEGIBLE CHARGES	BENEFITS AT %
BB	12200	07						
CB	12200	08						
DB	12200	09						
EB	12200	10						
FB	12200	11						
GB	12100	01				1,300.00		
HB								
IB	12100	01				400.00		
JB								
KB								
LB								
MB								
TOTAL		$		$		1,700.00	$	

CDS CODE	TYPE OF CHARGE			
BS	HOSPITAL ROOM AND BOARD FROM		TO	
	MISC. HOSPITAL CHARGES			
	SURGERY			
	MATERNITY BENEFIT			
	OUT PATIENT BENEFIT-ACCIDENT			
GS	MONTHLY BENEFIT FROM	04/14/06	TO	05/14/06
HS	1 MONTHLY BENEFT			
IS	ABI 04/14/06-05/14/06			
JS				
KS				
LS				
MS				

DS CODE	INSURED	TAX ID
TS	DONNA MATHEWS	

CDS CODE	PAYEE NAME AND ADDRESS
Y1	DONNA MATHEWS
Y2	REDACTED
Z1	CALISTOGA, GA 94515
Z2	
Z3	

PREPARED BY	APPROVAL
ELAINE BOURG	

REDACTED

PAL 0853

STATEMENT

DESCRIPTION OF BENEFITS			AMOUNT
POLICY NO. 1285764 CLAIM NO. 061007			
MONTHLY BENEFITS FROM 031406 TO 041406		DAYS	1,300.00
ABI 021406 031406			400.00
INSURED: DONNA MATEWS			

JUL 14 2006

CHECK NO. 063037871 CHECK AMOUNT $1,700.00

THE ATTACHED CHECK COVERS FULL PAYMENT OF ITEMS SHOWN IN STATEMENT ABOVE. PLEASE DETACH THIS STATEMENT BEFORE PRESENTING CHECK FOR PAYMENT.

PAN-AMERICAN LIFE INSURANCE COMPANY

000010 ENDORSEMENT OF THIS CHECK MUST BE IN HANDWRITING OF PAYEE OR PAYEES EXACTLY IN CONFORMITY WITH THE NAME OR NAMES AS WRITTEN 280AH AH

84-13/654 NO. 063037871

PAN AMERICAN LIFE

AMOUNT $******1,700.00**

PAY TO THE ORDER OF:

DONNA MATEWS
REDACTED
CALISTOGA GA 94515

$1,700.00

DATE JUL 13,2006

NOT VALID AFTER 90 DAYS OF ISSUE

BANK ONE
NEW ORLEANS, LA.

NON NEGOTIABLE

⑈063037871⑈ ⑆065400137⑆ 011002943?⑈

REDACTED

PAL 0854

ACCIDENT AND HEALTH CLAIM CHECK REQUEST/ WORK SHEET

POLICY NUMBER										DATE			
1285-764		CALIFORNI											
FORM NUMBER	BO	ST/CTRY	AGENCY	AGENT	AGENT	CLAIM NUMBER	INS.	AGE	INCURR DATE	REPORT DATE	CAUSE	A/S	COINS
8142		4				06-1007	1	53	12/14/2006	2/6/2006	419		
CDS CODE	CASH ACCOUNT	CHECK AMOUNT		AUTH		NO.CHK	NO ACCT	CHECK NUMBER	9/1/2004				
A1	51448	$ 1,700.00		MRJ1					CRAH	607072			

CDS CODE	ACCOUNT	A & H CD	TOTAL CHARGES	INELEGIBLE	SEE REV	100% BENEFITS	ELEGIBLE CHARGES	BENEFITS AT %
BB	12200	07						
CB	12200	08						
DB	12200	09						
EB	12200	10						
FB	12200	11						
GB	12100	01				1,300.00		
HB								
IB	12100	01				400.00		
JB								
KB								
LB								
MB								
TOTAL			$			1,700.00	$	

CDS CODE	TYPE OF CHARGE				
BS	HOSPITAL ROOM AND BOARD FROM		TO		
	MISC. HOSPITAL CHARGES				
	SURGERY				
	MATERNITY BENEFIT				
	OUT PATIENT BENEFIT-ACCIDENT				
GS	MONTHLY BENEFIT FROM	03/14/06	TO	04/14/06	
HS	1 MONTHLY BENEFT				
IS	ABI 02/14/06-03/14/06				
JS					
KS					
LS					
MS					

REDACTED

CDS CODE	INSURED	TAX ID
TS	DONNA MATHEWS	

CDS CODE	PAYEE NAME AND ADDRESS
Y1	DONNA MATHEWS
Y2	REDACTED
Z1	CALISTOGA, GA 94515
Z2	
Z3	

PREPARED BY	APPROVAL
ELAINE BOURG	

STATEMENT

DESCRIPTION OF BENEFITS		AMOUNT
POLICY NO. 1285764 CLAIM NO. 061007		
MONTHLY BENEFITS FROM 021405 TO 031606	DAYS	1,300.00
		400.00
INSURED: DONNA MATHEWS		
CHECK NO. 063032875	CHECK AMOUNT	$1,700.00

THE ATTACHED CHECK COVERS FULL PAYMENT OF ITEMS SHOWN IN STATEMENT ABOVE. PLEASE DETACH THIS STATEMENT BEFORE PRESENTING CHECK FOR PAYMENT.

PAN-AMERICAN LIFE INSURANCE COMPANY

000004 ENDORSEMENT OF THIS CHECK MUST BE IN HANDWRITING OF PAYEE OR PAYEES EXACTLY IN CONFORMITY WITH THE NAME OR NAMES AS WRITTEN 280AH AH

84-13 / 654

No. 063032875

PAN AMERICAN LIFE

DATE
MAR 06, 2006

NOT VALID AFTER 90 DAYS OF ISSUE

PAY TO THE ORDER OF:
DONNA MATHEWS
REDACTED
CALISTOGA CA 94515

MAR 07 2006

AMOUNT
$******1,700.00**

$1,700.00
DOLLAR ONE CON SEVEN ZERO ZERO PER ZERO ZERO

BANK ONE
NEW ORLEANS, LA.

NON NEGOTIABLE

⑈063032875⑈ ⑆065400137⑆ 011002943 7⑈

REDACTED

PAL 0856

ACCIDENT AND HEALTH CLAIM CHECK REQUEST/ WORK SHEET

POLICY NUMBER									DATE			
1285-764	CALIFORNI								3/6/2006			
FORM NUMBER	BO	ST/CTRY	AGENCY	AGENT	AGENT	CLAIM NUMBER	INS.	AGE	INCURR DATE	REPORT DATE	CAUSE	A/S	COINS
8142		4				06-1007	1	53	12/14/2005	2/6/2006			
CDS CODE	CASH ACCOUNT	CHECK AMOUNT		AUTH		NO.CHK	NO ACCT	CHECK NUMBER	REQUEST NUMBER				
A1	51448	$ 1,700.00		MRJ1					CRAH 603051				

CDS CODE	ACCOUNT	A & H CD	TOTAL CHARGES	INELEGIBLE	SEE REV	100% BENEFITS	ELEGIBLE CHARGES	BENEFITS AT %
BB	12200	07						
CB	12200	08						
DB	12200	09						
EB	12200	10						
FB	12200	11						
GB	12100	01				1,300.00		
HB								
IB	12100	01				400.00		
JB								
KB								
LB								
MB								
TOTAL		$		$		1,700.00	$	

CDS CODE	TYPE OF CHARGE			
BS	HOSPITAL ROOM AND BOARD FROM		TO	
	MISC. HOSPITAL CHARGES			
	SURGERY			
	MATERNITY BENEFIT			
	OUT PATIENT BENEFIT-ACCIDENT			
GS	MONTHLY BENEFIT FROM	02/14/06	TO	03/14/06
HS	1 Monthly Benefit			
IS	ABI 02/14/06 - 03/14/06			
JS				
KS				
LS				
MS				

REDACTED

CDS CODE	INSURED
TS	DONNA MATHEWS

TAX ID

CDS CODE	PAYEE NAME AND ADDRESS
Y1	DONNA MATHEWS
Y2	REDACTED
Z1	CALISTOGA, CA 94515
Z2	
Z3	

PREPARED BY	APPROVAL
ELAINE BOURG	

ACCIDENT AND HEALTH CLAIM CHECK REQUEST/ WORK SHEET

POLICY NUMBER									DATE				
1257-758		CALIFORNI											
FORM NUMBER	BO	ST/CTRY	AGENCY	AGENT	AGENT	CLAIM NUMBER	INS.	AGE	INCURR DATE	REPORT DATE	CAUSE	A/S	COINS
7h01		4				06-1005	1	53	12/14/2006	2/6/2006	419		
CDS CODE	CASH ACCOUNT	CHECK AMOUNT		AUTH		NO.CHK	NO ACCT	CHECK NUMBER	9/1/2004				
A1	51448	$ -		MRJ1					CRAH	608065			

CDS CODE	ACCOUNT	A & H CD	TOTAL CHARGES	INELEGIBLE	SEE REV	100% BENEFITS	ELEGIBLE CHARGES	BENEFITS AT %
BB	12200	07						
CB	12200	08						-
DB	12200	09						
EB	12200	10						
FB	12200	11						
GB	12100	01				*500.00-		
HB								
IB								
JB								
KB								
LB								
MB								
TOTAL		$		$		0.00	$	

CDS CODE	TYPE OF CHARGE				
BS	HOSPITAL ROOM AND BOARD FROM		TO		
	MISC. HOSPITAL CHARGES				
	SURGERY				
	MATERNITY BENEFIT				
	OUT PATIENT BENEFIT-ACCIDENT				
GS	MONTHLY BENEFIT FROM	04/14/06	TO	05/14/06	
HS	1 MONTHLY BENEFT				
IS					
JS					
KS					
LS					
MS					

CDS CODE	INSURED
TS	DONNA MATHEWS

TAX ID

*$500.00 was deducted from the payment because of overpayment on benefit on 7/13/06.

CDS CODE	PAYEE NAME AND ADDRESS
Y1	DONNA MATHEWS
Y2	REDACTED
Z1	CALISTOGA, GA 94515
Z2	
Z3	

PREPARED BY	APPROVAL
ELAINE BOURG	

REDACTED